HealthPlus™

Custom SOM Medicare Advantage $125/$250 – 100% Plan
HMO Benefit Summary *(Internal Code BU)*
Effective 1/1/2016

This is intended to serve as an easy-to-read Summary of Benefits. It is not a contract. It does not modify or take the place of the Evidence of Coverage and/or applicable summary of benefits.

Services	Member Responsibility
Deductible (ER and Urgent Care copays count toward meeting deductible)	$125 per Member
Part C Maximum Out-of-Pocket (includes flat dollar copays, except for prescription drugs)	$500 per Member
PREVENTIVE SERVICES	
Annual Physical	$0 Copay
Annual Wellness Exam	$0 Copay
Abdominal Aortic Aneurysm Screening	$0 Copay
Bone Mass Measurement	$0 Copay
Cardiovascular Screening	$0 Copay
Cervical and Vaginal Cancer Screening (Pap test and pelvic exam)	$0 Copay
Colorectal Cancer Screening	$0 Copay
Diabetes Screening	$0 Copay
Influenza Vaccine	$0 Copay
Hepatitis B Vaccine	$0 Copay
HIV Screening	$0 Copay
Breast Cancer Screening (Mammogram)	$0 Copay
Medical Nutrition Therapy Services	$0 Copay
Pneumococcal Vaccine	$0 Copay
Prostate Cancer Screening	$0 Copay
Smoking Cessation	$0 Copay
Welcome to Medicare Physical Exam	$0 Copay
PHYSICIAN OFFICE SERVICES	
Primary Care Physician Services, including Office Visits	$20 Copay per Visit
Specialist Office Services, including Office Visits	$20 Copay per Visit
*Chiropractic Services (Manual manipulation of the spine to correct subluxation; referral required)	$20 Copay after Deductible
EMERGENCY MEDICAL CARE	
Hospital Emergency Room (worldwide coverage)	$65 Copay (waived if admitted)
Freestanding Emergency center or Urgent Care Center (worldwide coverage)	$20 Copay per Visit
*Ambulance Services	$0 Copay after Deductible
DIAGNOSTIC SERVICES	
Laboratory and Pathology Tests	$0 Copay
X-Rays and other Diagnostic and Therapeutic Radiological Services	$0 Copay after Deductible
HOSPITAL SERVICES	
*Inpatient Care	$0 Copay after Deductible
*Outpatient Surgery	$0 Copay after Deductible
*Ambulatory Surgical Center (ASC) Services	$0 Copay after Deductible
Other Outpatient Services	$0 Copay after Deductible

ALTERNATIVES TO HOSPITAL CARE	
*Skilled Nursing Facility *(limited to 120 days per year)*	$0 Copay after Deductible
Hospice Care	When you enroll in a Medicare-certified hospice program, your hospice services are covered by original Medicare.
*Home Health Care *(does not cover custodial care or general housekeeping services; prior authorization required on 61st day and beyond)*	$20 Copay per Day after Deductible
MENTAL HEALTH CARE	
*Inpatient Care *(up to 190 days per lifetime)*	$0 Copay after Deductible
*Outpatient Care *(prior authorization required after 20th visit)*	$20 Copay per Visit
SUBSTANCE ABUSE SERVICES *(Limited to Medically Necessary treatment)*	
*Inpatient Care	$0 Copay after Deductible
*Outpatient Care	$20 Copay per Visit
DIABETES PROGRAMS AND SUPPLIES	
Self-Management Training	$0 Copay
Diabetes Monitoring Supplies	$0 Copay
Therapeutic Shoes or Inserts	$0 Copay
KIDNEY DISEASE AND CONDITIONS	
Renal Dialysis	$0 Copay after Deductible
Kidney Disease Education Service	$0 Copay
PRESCRIPTION DRUGS (Part D Maximum Out-of-Pocket is $1,500)	
Retail	
Select Generic Maintenance/Preventive Medications	$0 Copay per prescription
Preferred Generic	$10 Copay per prescription
Generic	$10 Copay per prescription
Preferred Brand	$30 Copay per prescription
Non-Preferred Brand	$60 Copay per prescription
Specialty	$60 Copay per prescription
90-Day supply at Participating "Ask for 90" Retail Pharmacies or Mail Order through Express Scripts	
Select Generic Maintenance/Preventive Medications	$0 Copay per prescription
Preferred Generic	$20 Copay per prescription
Generic	$20 Copay per prescription
Preferred Brand	$60 Copay per prescription
Non-Preferred Brand	$120 Copay per prescription
Specialty	$120 Copay per prescription
Catastrophic Coverage Once You Have Reached $4,850 True Out-of-Pocket in a Calendar Year	
Preferred Generic or Generic	Greater of $2.95 Copay or 5% coinsurance
Preferred or Non-Preferred Brand, & Specialty	Greater of $7.40 Copay or 5% coinsurance
OTHER SERVICES	
*Short-Term Outpatient Physical, Speech and Occupational Therapy	$20 Copay per Day
*Durable Medical Equipment	$0 Copay
*Prosthetic and Orthotic Appliances	$0 Copay
*Podiatry Services (referral required)	$20 Copay after Deductible
Medicare Part B-Covered Drugs	$0 Copay
HEARING CARE	
Preventive Hearing Services	$0 Copay
Hearing Aids *(limited to 1 standard hearing aid per ear every 12 months)*	$0 Copay

*Certain services, as noted with asterisk, require prior authorization. If authorization is not obtained by member or ordering physician, member may be responsible for entire cost of services.

Not Covered (Exclusions: (For a more complete list, please see your Benefit Rider; Benefit Limitations and Exclusions Section)

- Services considered not reasonable and necessary, according to the standards of Original Medicare, unless these services are listed by our plan as covered services.
- Experimental medical and surgical procedures, equipment and medications, unless covered by Original Medicare or under a Medicare-approved clinical research study. Experimental procedures and items are those items and procedures determined by our plan and Original Medicare to not be generally accepted by the medical community.
- Surgical treatment for morbid obesity, except when it is considered medically necessary and covered under Original Medicare.
- Private room in a hospital, except when it is considered medically necessary.
- Private duty nurses.
- Personal items in your room at a hospital or a skilled nursing facility, such as a telephone or a television.
- Full-time nursing care in your home.
- Custodial care, unless it is provided with covered skilled nursing care and/or skilled rehabilitation services. Custodial care, or non-skilled care, is care that helps you with activities of daily living, such as bathing or dressing.
- Homemaker services include basic household assistance, including light housekeeping or light meal preparation.
- Fees charged by your immediate relatives or members of your household.
- Meals delivered to your home.
- Elective or voluntary enhancement procedures or services (including weight loss, hair growth, sexual performance, athletic performance, cosmetic purposes, anti-aging and mental performance), except when medically necessary.
- Cosmetic surgery or procedures, unless because of an accidental injury or to improve a malformed part of the body. However, all stages of reconstruction are covered for a breast after a mastectomy, as well as for the unaffected breast to produce a symmetrical appearance.
- Chiropractic care, other than manual manipulation of the spine consistent with Medicare coverage guidelines.
- Routine foot care, except for the limited coverage provided according to Medicare guidelines.
- Orthopedic shoes, unless the shoes are part of a leg brace and are included in the cost of the brace or the shoes are for a person with diabetic foot disease.
- Supportive devices for the feet, except for orthopedic or therapeutic shoes for people with diabetic foot disease.
- Radial keratotomy, LASIK surgery, vision therapy and other low vision aids. However, eyeglasses are covered for people after cataract surgery.
- Reversal of sterilization procedures, sex change operations, and non-prescription contraceptive supplies.
- Acupuncture.
- Naturopath services (uses natural or alternative treatments).
- Services provided to veterans in Veterans Affairs (VA) facilities. However, when emergency services are received at VA hospital and the VA cost sharing is more than the cost sharing under our plan, we will reimburse veterans for the difference. Members are still responsible for our cost-sharing amounts.

The plan will not cover the excluded services listed above. Even if you receive the services at an emergency facility, the excluded services are still not covered.